

STATE OF ILLINOIS

Page 2

Facility Name & ID Number Snyder Village Health Center# 0033647Report Period Beginning: #####Ending: #####

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>105</u>	Skilled (SNF)	<u>105</u>	<u>38,325</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>105</u>	TOTALS	<u>105</u>	<u>38,325</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>293</u>	<u>739</u>	<u>2,215</u>	<u>3,247</u>	8
9	SNF/PED					9
10	ICF	<u>9,326</u>	<u>23,508</u>		<u>32,834</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>9,619</u>	<u>24,247</u>	<u>2,215</u>	<u>36,081</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 94.14%D. How many bed-hold days during this year were paid by Public Aid?
59 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NoneF. Does the facility maintain a daily midnight census? YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?
YES ☒ NO ☐H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☐ NO ☒I. On what date did you start providing long term care at this location?
Date started 30-Jun-88J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 30-Jun-88 NO ☐K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number
of beds certified 105 and days of care provided 2,215Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED
CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/03 Fiscal Year: 12/31/03
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number

Snyder Village Health Center

0033647

Report Period Beginning:

1/1/2003

Ending:

12/31/2003

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	277,258		21,875	299,133		299,133		299,133			1
2	Food Purchase		190,684		190,684		190,684	(47,853)	142,831			2
3	Housekeeping	164,836	19,497	654	184,987		184,987	(1,318)	183,669			3
4	Laundry	74,337	17,326		91,663		91,663		91,663			4
5	Heat and Other Utilities			121,423	121,423		121,423	(24,878)	96,545			5
6	Maintenance	101,224	24,008	18,647	143,879		143,879	(454)	143,425			6
7	Other (specify):*											7
8	TOTAL General Services	617,655	251,515	162,599	1,031,769		1,031,769	(74,503)	957,266			8
	B. Health Care and Programs											
9	Medical Director			275	275		275		275			9
10	Nursing and Medical Records	2,458,317	59,466	16,472	2,534,255		2,534,255	(14,849)	2,519,406			10
10a	Therapy	9,520	1,573	138,630	149,723		149,723		149,723			10a
11	Activities	110,901	5,633	861	117,395		117,395		117,395			11
12	Social Services	74,387	812	1,239	76,438		76,438	(4,049)	72,389			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,653,125	67,484	157,477	2,878,086		2,878,086	(18,898)	2,859,188			16
	C. General Administration											
17	Administrative	61,680			61,680		61,680		61,680			17
18	Directors Fees											18
19	Professional Services			27,861	27,861		27,861		27,861			19
20	Dues, Fees, Subscriptions & Promotions			32,795	32,795	592	33,387	(3,460)	29,927			20
21	Clerical & General Office Expenses	182,704	16,609	41,806	241,119	(531)	240,588	(103,989)	136,599			21
22	Employee Benefits & Payroll Taxes			825,709	825,709	(592)	825,117		825,117			22
23	Inservice Training & Education			1,203	1,203		1,203		1,203			23
24	Travel and Seminar			9,966	9,966	531	10,497		10,497			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			58,759	58,759		58,759		58,759			26
27	Other (specify):*											27
28	TOTAL General Administration	244,384	16,609	998,099	1,259,092		1,259,092	(107,449)	1,151,643			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,515,164	335,608	1,318,175	5,168,947		5,168,947	(200,850)	4,968,097			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification

STATE OF ILLINOIS

Page 4

Facility Name & ID Number Snyder Village Health Center

#0033647

Report Period Beginning:

1/1/2003

Ending:

12/31/2003

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			198,990	198,990		198,990	4,383	203,373			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			109,047	109,047		109,047	(39,868)	69,179			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			8,172	8,172		8,172		8,172			35
36	Other (specify):*											36
37	TOTAL Ownership			316,209	316,209		316,209	(35,485)	280,724			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		172,011	8,203	180,214		180,214		180,214			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			57,487	57,487		57,487		57,487			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		172,011	65,690	237,701		237,701		237,701			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,515,164	507,619	1,700,074	5,722,857		5,722,857	(236,335)	5,486,522			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

VI. ADJUSTMENT DETAIL A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(20,471)	2.2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	4,383	30.3		9
10	Interest and Other Investment Income	(39,868)	32.3		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional		43.3		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(3,460)	20.3		28
29	Other-Attach Schedule	(176,919)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (236,335)		\$	30

OHF USE ONLY							
48		49		50		51	52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (236,335)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	\$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
This work paper section is not applicable.						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☒ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V		\$			\$	\$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$	\$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Snyder Village Health Center # 0033647 Report Period Beginning: 1/1/2003 Ending: 12/31/2003

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	This work paper section is not applicable.								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number Snyder Village Health Center

0033647

Report Period Beginning:

1/1/2003

Ending:

12/31/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number _____

Fax Number _____

B. Show the allocation of costs below. If necessary, please attach worksheets

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	This work paper section is not applicable.				\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

STATE OF ILLINOIS

Page 9

Facility Name & ID Number Snyder Village Health Center # 0033647 Report Period Beginning: 1/1/2003 Ending: 12/31/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Commerce Bank		X	Building	\$ 12,758	8/1/1987	\$ 3,450,000	\$ 1,498,773	9/1/2026	5.071%	\$ 80,997	1	
2	CDAP Village Metamora		X	Building	4,340	Various	614,000	225,538	Various	3.750%	9,136	2	
3	Commerce Bank		X	Bldg Construction	4,855	2/1/2001	500,000	233,729	5/31/2007	4.250%	10,941	3	
4	Commerce Bank		X	Patient Transport Vehicle	562	11/1/2002	29,900	23,376	10/1/2007	4.250%	1,113	4	
5	Woodford County		X	Bldg Construction	1,887	12/1/2000	100,000	41,307	11/1/2005	5.000%	2,566	5	
	Working Capital												
6	Gift Annuity		X	Building	510	Various	84,000	70,032	Various		4,294	6	
7												7	
8									Less: Interest Income		(39,868)	8	
9	TOTAL Facility Related				\$ 24,912		\$ 4,777,900	\$ 2,092,753			\$ 69,179	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 4,777,900	\$ 2,092,753			\$ 69,179	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line #

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

Facility Name & ID Number Snyder Village Health Center# 0033647

Report Period Beginning:

1/1/2003

Ending:

12/31/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.																							
1. Real Estate Tax accrual used on 2002 report.		\$	1																				
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	2																				
3. Under or (over) accrual (line 2 minus line 1).		\$	3																				
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	4																				
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5																				
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6																				
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6		\$	7																				
Real Estate Tax History:																							
Real Estate Tax Bill for Calendar Year:	1998 _____ 8 1999 _____ 9 2000 _____ 10 2001 _____ 11 2002 _____ 12	<table border="1"> <tr> <td></td> <td colspan="2">FOR OHF USE ONLY</td> <td></td> </tr> <tr> <td>13</td> <td>FROM R. E. TAX STATEMENT FOR 2002</td> <td>\$</td> <td>13</td> </tr> <tr> <td>14</td> <td>PLUS APPEAL COST FROM LINE 5</td> <td>\$</td> <td>14</td> </tr> <tr> <td>15</td> <td>LESS REFUND FROM LINE 6</td> <td>\$</td> <td>15</td> </tr> <tr> <td>16</td> <td>AMOUNT TO USE FOR RATE CALCULATION</td> <td>\$</td> <td>16</td> </tr> </table>			FOR OHF USE ONLY			13	FROM R. E. TAX STATEMENT FOR 2002	\$	13	14	PLUS APPEAL COST FROM LINE 5	\$	14	15	LESS REFUND FROM LINE 6	\$	15	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16
	FOR OHF USE ONLY																						
13	FROM R. E. TAX STATEMENT FOR 2002	\$	13																				
14	PLUS APPEAL COST FROM LINE 5	\$	14																				
15	LESS REFUND FROM LINE 6	\$	15																				
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16																				

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Snyder Village Health Center COUNTY Woodford
 FACILITY IDPH LICENSE NUMBER 0033647
 CONTACT PERSON REGARDING THIS REPORT Keith Swartzentruber
 TELEPHONE (309) 367-4300 FAX #: (309) 367-2235

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
2. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
3. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
4. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
5. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
6. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
7. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
8. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
9. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
10. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
TOTALS		\$ <u> </u>	\$ <u> </u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

Facility Name & ID Number Snyder Village Health Center

0033647

Report Period Beginning:

1/1/2003

Ending:

#####

X. BUILDING AND GENERAL INFORMATION

A. Square Feet: 36,870 B. General Construction Type: Exterior Brick Frame Wood & Steel Number of Stories One

C. Does the Operating Entity? ☒ (a) Own the Facility ☐ (b) Rent from a Related Organization. ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? ☒ (a) Own the Equipment ☐ (b) Rent equipment from a Related Organization. ☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's ground (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc. List entity name, type of business, square footage, and number of beds/units available (where applicable)

Snyder Village Retirement Community Apartments - 41 Apartments @ 38,793 F2

Snyder Village Retirement Community Cottages - 118 Cottages @ 283,200 F2

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☒ NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Home	155,422	1987	\$ 43,000	1
2	Nursing Home		2001	1,300	2
3	TOTALS	155,422		\$ 44,300	3

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	2 FOR OHF USE ONLY	3 Year Acquired	4 Year Constructed	5 Cost	6 Current Book Depreciation	7 Life in Years	8 Straight Line Depreciation	9 Adjustments	10 Accumulated Depreciation	11
4	61		1988	1988	\$ 1,929,231	\$ 42,872	45	\$ 42,872		\$ 664,514	4
5			1992	1992	127,495	2,833	45	2,833		32,818	5
6			1992	1992	33,830	1,353	25	1,353		15,110	6
7	18		1994	1994	600,872	13,353	45	13,353		131,302	7
8	26		1994	1994	1,256,597	27,924	45	27,924		253,646	8
	Improvement Type**										
9	Fire Control System			10/01/89	5,152	258	20	258		3,672	9
10	Century Tub			10/01/89	7,694		10			7,694	10
11	Asphalt			07/01/90	1,820	91	20	91		1,229	11
12	Alzheimer's Courtyard			08/01/90	3,644		10			3,644	12
13	Heat Exchanger			03/01/90	1,650		10			1,650	13
14	Tub			05/01/91	1,465		10			1,465	14
15	Door Locks			12/01/91	1,400	70	20	70		846	15
16	Door Locks			04/01/92	1,200	60	20	60		705	16
17	Patio			06/01/92	1,219		10			1,219	17
18	Entrance Light			06/01/93	619	26	10	25	(1)	619	18
19	Land Improvement			12/01/94	25,546	1,277	20	1,277		11,601	19
20	Services Windows			03/01/95	201,662	4,481	45	4,481		37,588	20
21	Landscaping			01/01/95	13,848	692	20	692		4,056	21
22	Canopy			12/01/95	1,102	55	20	55		445	22
23	Electrical Maintenance			09/01/95	595	40	15	40		331	23
24	Door Locks			08/01/95	505	34	15	34		284	24
25	Front Canopy			09/01/96	44,945	999	45	999		6,476	25
26	Tower			05/01/96	7,360	368	20	368		2,821	26
27	Door Open			09/01/96	3,344	334	10	334		2,451	27
28	Landscaping			07/01/97	1,500	75	20	75		488	28
29	Front Door Wiring			03/01/97	1,396	70	20	70		477	29
30	Kelly Glass			01/01/98	3,527	176	20	176		1,057	30
31	MTCO Phone System			08/01/98	18,914	757	25	757		3,036	31
32	Carpet			11/01/98	15,719	1,572	10	1,572		8,122	32
33	Heater			04/01/99	1,784	178	10	178		846	33
34	Security Camera			01/01/99	2,510	167	15	167		836	34
35	Motion Detector			01/01/99	790		10	79	79	395	35
36	Shelving			01/01/99	673		10	67		335	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

STATE OF ILLINOIS

Page 12A

Facility Name & ID Number Snyder Village Health Center

0033647

Report Period Beginning:

1/1/2003

Ending:

12/31/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Automatic Door Open	12/01/00	\$ 5,449	\$	15	\$ 363	\$ 363	\$ 1,271	37
38	Blacktop	12/01/00	21,736	1,087	20	1,087		3,351	38
39	Sunroom	05/01/00	86,410	1,920	45	1,920		6,717	39
40	Generator	02/01/00	36,206	1,810	20	1,810		6,261	40
41	Time Clock	03/01/00	7,789	1,558	5	1,558		5,972	41
42	Motion Detector	05/01/00	5,714	571	10	571		2,094	42
43	Nursing Office Addition	04/01/01	751,810	16,707	45	16,707		41,858	43
44	Sunroom	01/01/01	11,315	1,132	10	1,132		3,396	44
45	Tower	06/01/01	5,640	564	10	564		1,457	45
46	Door	11/01/01	2,545	255	10	255		552	46
47	Carpet	11/01/01	3,529	353	10	353		765	47
48	Landscaping	04/01/01	4,943	247	20	247		679	48
49	Blacktop	11/01/01	12,054	603	20	603		1,307	49
50	Roof	06/01/02	36,779	2,452	15	1,431	(1,021)	2,862	50
51	Hall 2 Room Alert	02/01/02	5,015	1,003	5	915	(88)	1,830	51
52	Door, Tile, Drapes, Wall	03/01/03	4,557	475	8	475		475	52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 5,321,099	\$ 130,852		\$ 130,251	\$ (668)	\$ 1,282,625	70

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Snyder Village Health Center

0033647

Report Period Beginning:

1/1/2003

Ending:

12/31/2003

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 481,888	\$ 48,349	\$ 48,349	\$	various	\$ 368,532	71
72	Current Year Purchases	3,016	494	494		various	494	72
73	Fully Depreciated Assets	306,944				various	306,944	73
74								74
75	TOTALS	\$ 791,848	\$ 48,843	\$ 48,843	\$		\$ 675,970	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Resident Care	1985 Ford Van	01/01/91	\$ 3,130	\$	\$	\$	3	\$ 3,130	76
77	Resident Transportation	1994 Van	01/01/94	47,025	4,703	4,703		10	43,499	77
78	Resident Transportation	1996 Van	01/01/96	51,573	5,157	5,157		10	36,530	78
79	Resident Care	1992 Truck	01/01/97	16,367				10	16,367	79
80	TOTALS			\$ 170,254	\$ 19,295	\$ 24,279	\$ 4,984		\$ 132,402	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 6,327,501 81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 198,990 82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 203,373 83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 4,316 84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,090,997 85

**

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	Construction in Progress	\$ 7,669	92
93			93
94			94
95		\$ 7,669	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Snyder Village Health Center

0033647

Report Period Beginning:

1/1/2003

Ending:

12/31/2003

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$	\$	\$	\$		\$	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$	\$	\$	\$		\$	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Maintenance Use	1999 Tate Truck	01/01/99	\$ 6,850	\$ 1,370	\$ 1,370		5	\$ 6,507	76
77	Maintenance Use	1999 Grimm Truck	01/01/99	15,409	3,082	3,082		5	13,098	77
78	Patient Transport	2000 Ford Van	09/01/02	29,900	4,983	9,967	4,984	3	13,271	78
79										79
80	TOTALS			\$ 52,159	\$ 9,435	\$ 14,419	\$ 4,984		\$ 32,876	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 85

**

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions.

☐ YES ☒ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

**

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? _____

☐ YES ☒ NO

16. Rental Amount for movable equipment: \$ 8,172 Description: Postage Meter (\$1,053) and Copier (\$7,119)

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2004 \$ _____

13. /2005 \$ _____

14. /2006 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number

Snyder Village Health Center

#

0033647

Report Period Beginning:

1/1/2003

Ending:

#####

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?	<input type="checkbox"/> YES	2. CLASSROOM PORTION:	3. CLINICAL PORTION:
	<input checked="" type="checkbox"/> NO	IN-HOUSE PROGRAM <input type="checkbox"/>	IN-HOUSE PROGRAM <input type="checkbox"/>
		IN OTHER FACILITY <input type="checkbox"/>	IN OTHER FACILITY <input checked="" type="checkbox"/>
		COMMUNITY COLLEGE <input checked="" type="checkbox"/>	HOURS PER AIDE <u>40</u>
		HOURS PER AIDE <u>80</u>	

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

B. EXPENSES

ALLOCATION OF COSTS

(d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides

(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number Snyder Village Health Center

0033647

Report Period Beginning:

1/1/2003

Ending:

12/31/2003

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a.3	hrs	\$	206	\$ 10,787	\$	206	\$ 10,787	1
2	Licensed Speech and Language Development Therapist	10a.3	hrs		121	6,166		121	6,166	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a.3	hrs		301	16,657	1,573	301	18,230	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39.2	# of prescripts				79,503		79,503	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Medical Supplies	39.2					92,508		92,508	13
14	TOTAL			\$	628	\$ 33,610	\$ 173,583	628	\$ 207,194	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 655,558	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance (28,500))	639,610		3
4	Supply Inventory (priced at FIFO)	24,800		4
5	Short-Term Investments	239,755		5
6	Prepaid Insurance	10,133		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,541,356	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	44,149		12
13	Land	44,300		13
14	Buildings, at Historical Cost	5,155,936		14
15	Leasehold Improvements, at Historical Cos			15
16	Equipment, at Historical Cost	1,043,042		16
17	Accumulated Depreciation (book methods)	(2,012,991)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spec Resident in Need / Endowm	162,464		22
23	Other(specify): Construction in Progress	7,669		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 4,444,569	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,985,925	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ (72,746)	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	(234,820)		30
31	Accrued Taxes Payable (excluding real estate taxes)	646		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Employee Benefits Payable	(117,603)		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ (424,523)	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	(2,092,753)		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ (2,092,753)	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ (2,517,276)	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (3,468,649)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ (5,985,925)	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,437,539	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,437,539	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	31,109	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe) Rounding	1	16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 31,110	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 3,468,649	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All require

classifications of revenue and expense must be provided on this form, even if financial statements are attached

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ (5,455,687)	1
2	Discounts and Allowances for all Levels	778,164	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ (4,677,523)	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	(351,664)	6
7	Oxygen	(74,425)	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ (426,089)	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	(3,556)	11
12	Gift and Coffee Shop	(9,938)	12
13	Barber and Beauty Care	(4,329)	13
14	Non-Patient Meals	(20,471)	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	(182,083)	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	(11,021)	20
21	Other Medical Services	(149,632)	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ (381,030)	23
	D. Non-Operating Revenue		
24	Contributions	(86,490)	24
25	Interest and Other Investment Income***	(39,868)	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ (126,358)	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Non-Care Revenues	(126,410)	28
28a	Other Income	(16,556)	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ (142,966)	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ (5,753,966)	30

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,031,769	31
32	Health Care	2,878,086	32
33	General Administration	1,259,092	33
	B. Capital Expense		
34	Ownership	316,209	34
	C. Ancillary Expense		
35	Special Cost Centers	180,214	35
36	Provider Participation Fee	57,487	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,722,857	40
41	Income before Income Taxes (line 30 minus line 40)**	(31,109)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (31,109)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
 (This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,844	2,063	\$ 46,577	\$ 22.58	1
2	Assistant Director of Nursing					2
3	Registered Nurses	31,075	34,219	695,576	20.33	3
4	Licensed Practical Nurses	16,952	18,544	307,122	16.56	4
5	Nurse Aides & Orderlies	108,111	117,668	1,355,497	11.52	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	772	848	9,520	11.23	8
9	Activity Director	1,950	2,125	21,142	9.95	9
10	Activity Assistants	9,582	10,443	89,759	8.60	10
11	Social Service Workers	5,629	6,510	74,387		11
12	Dietician					12
13	Food Service Supervisor	3,309	4,087	54,840	13.42	13
14	Head Cook	6,539	7,838	73,780	9.41	14
15	Cook Helpers/Assistants	17,856	18,461	148,638	8.05	15
16	Dishwashers					16
17	Maintenance Workers	7,288	8,275	101,224	12.23	17
18	Housekeepers	15,630	17,111	164,836	9.63	18
19	Laundry	7,904	8,877	74,337	8.37	19
20	Administrator	1,768	2,219	61,680	27.80	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,896	2,080	31,987	15.38	23
24	Clerical	9,952	11,563	128,737	11.13	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>Ward Clerk</u>	4,493	4,950	53,545	10.82	33
34	TOTAL (lines 1 - 33)	252,550	277,881	\$ 3,493,184 *	\$ 12.57	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	197	\$ 7,390	1.3	35
36	Medical Director	2	275	9.3	36
37	Medical Records Consultant	4	100	10.3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	12	900	10.3	39
40	Physical Therapy Consultant	126	6,949	10a.3	40
41	Occupational Therapy Consultant	12	616	10a.3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	18	825	11.3	44
45	Social Service Consultant	24	1,214	12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	395	\$ 18,270		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	450	\$ 14,625	10.3	50
51	Licensed Practical Nurses			10.3	51
52	Nurse Aides			10.3	52
53	TOTAL (lines 50 - 52)	450	\$ 14,625		53

Ending: 12/31/2003

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	Carpentry	May 2001	\$ 1,244		\$	\$ 124	\$ 249	\$ 249	\$ 249	\$ 249	\$ 124	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$ 1,244		\$	\$ 124	\$ 249	\$ 249	\$ 249	\$ 249	\$ 124	\$	\$

Facility Name & ID Number Snyder Village Health Center

0033647

Report Period Beginning: 1/1/2003

Ending: #####

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Life Services Network of IL 5,736
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 6
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 24,737 Line 10.2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? _____
If YES, give effective date of lease. No
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over _____
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 57,487
This amount is to be recorded on line 42 of Schedule V
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? Yes OP Therapy For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions
- (15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. \$ _____ Has any meal income been offset against related costs? Yes Indicate the amount. \$ 20,471
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? _____
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Heinold Banwart LTD The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? Yes If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.